Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: License.wi.gov
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

PHARMACY EXAMINING BOARD

CHANGE IN DESIGNATED REPRESENTATIVE FOR A WHOLESALE DISTRIBUTOR OF PRESCRIPTION DRUGS

When a change in designated representative occurs for a Wisconsin licensed wholesale distributor of prescription drugs, a new Form 2812 must be completed and attached to this form. Form 2687 is also required for all newly listed Designated Representatives. The Designated Representative listed must meet all requirements of Wis. Stat. § 450.071(3)(c).

Please note: This change will not be approved until the required fingerprint check has been cleared and Form 2812 has been submitted and approved. **If applicant is accredited by the National Association of Boards of Pharmacy's Drug Distributor Accreditation (DDA) program the designated representative will not need to provide fingerprints.** To check to see if the current change has been updated go to the Department website at dsps.wi.gov – select "Self-Service," then "License Look Up." Please allow at least 20 business days for the change to occur.

Complete the following and return to the Pharmacy Examining Board at the address listed below.

Wholesale distributor facility that has a change in designated representative. (Complete Sections A-D)

A.

DOING BUSINESS AS (DBA) NAME OF FACILITY:
CURRENT WI LICENSE NUMBER:

NEW DESIGNATED REPRESENTATIVE

B.

Name and Address of Designated Responsible Representative for the Distribution of Prescription Drugs: The designated representative named below must complete the Designated Representative Form (2812) and Authorization Form (2687*) and attach to this form. *Required for all newly listed designated representatives.		
Full name of (new) Designated Representative		
Address		
City	State	Zip Code

C.

Read and sign below showing compliance.

I swear or affirm to the truthfulness of each item in Form 2812 for the Designated Representative listed above.

Date	Signature (If unable to provide a digital signature print and sign form.)
Date	Print full name
	Title

PREVIOUS DESIGNATED REPRESENTATIVE

D.

NAME (please print):
STARTING DATE:
ENDING DATE:

Return completed form to:

Department of Safety and Professional Services
Attn: Pharmacy Examining Board
P.O. Box 8935
Madison, WI 53708-8935